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Wednesday 29 March 2017

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Mercredi 29 mars 2017

Standing Committee on Public Accounts

2016 Annual Report, Auditor General:

Ministry of Health and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2016, vérificatrice générale :

Ministère de la Santé et des Soins de longue durée

Chair: Ernie Hardeman
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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Wednesday 29 March 2017

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Mercredi 29 mars 2017

The committee met at 1231 in room 151, following a closed session.

2016 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.11, physician billing.

The Chair (Mr. Ernie Hardeman): I call this meeting of public accounts to order. We're here this afternoon to hear delegations presenting on section 3.11 of the 2016 annual report of the Office of the Auditor General of Ontario. We have the Ministry of Health and Long-Term Care present. Thank you very much, sir, for being here.

With that, as we normally do, for the new committee members and for the delegations, we will start this afternoon with a presentation of 20 minutes to talk about whatever the ministry would like to share with the committee to help us in our deliberations as we deal with this section of the report. After the 20 minutes have been consumed, we will then start the questions and comments from the committee in 20-minute rotation. We will be starting with the third party this afternoon.

You're number one today.

M^me^ France Gélinas: How did I manage that? That never happens. Never mind. It's a very good idea.

The Chair (Mr. Ernie Hardeman): Oh, it happens sometimes.

We will have a rotation of 20 minutes for each caucus and then, after the 20 minutes, we will decide how much time is left to get us to 2:45 and, at that point, will divide that equally among the three parties to make the second rotation.

With that, again, thank you very much, Deputy, for being here. The floor is yours.

Dr. Bob Bell: Thank you, Chair. My name is Bob Bell. I'm the Deputy Minister of Health and Long-Term Care. I want to take this opportunity to thank you for the opportunity to address the Standing Committee on Public Accounts with respect to the Auditor General's report on physician billing.

With me are Pauline Ryan, director, health services branch, as well as a representative from her division, Dr. Garry Salisbury, and directors from our negotiation branch, David Clarke, and primary care branch, Mr. Phil Graham.

I'd like to take this opportunity to thank Ms. Bonnie Lysyk, the Auditor General, for her report. We welcome the recommendations contained in her report, which provide guidance to strengthen accountability in health care services in the province.

I'd now like to provide a high-level summary of the Auditor General's recommendations from the audit report and share some background information about physician billing to demonstrate the complexity of this area, how it has evolved over the years and the impact this evolution has had on the health care system.

I'd then like to proceed to provide specific accomplishments for each of the Auditor General's recommendations to date. This report provides 14 recommendations with 29 action items focusing on two payment programs—primary care patient enrolment and, secondly, fee-for-service—as well as two ancillary items: medical liability protection and cardiology rhythm strip billing.

The focus on physician payment models and the benefit of these models both for Ontarians seeking health care services and to fairly compensate physicians providing health care services is obviously the purpose that we're here to discuss. Many of the recommendations and reference areas the ministry has been considering and working to address. We appreciate the support received by the Auditor General's report.

Stepping back to 30,000 feet, we of course negotiate with the Ontario Medical Association to enter into a physician service agreement, which provides a contractual basis for any changes to physician payments. The last physician services agreement expired on March 31, 2014. The ministry has recently identified our negotiation team to act on behalf of the government in renewed negotiations with the Ontario Medical Association.

As we work on our mandate to deliver improved access, reduce wait times and improve the overall patient experience and the health of Ontarians, we will obviously only be stronger with a productive relationship with Ontario's physicians.

While it has been a short time since this report was released, I'm pleased to say that there has been substantial progress to identify deliverables and associated project timelines for each of the recommendations. Indeed, I think you'll see today that progress is already being made on some of these recommendations.

Before discussing the recommendations and our progress, I'd like to provide some context around physician payment and billing in Ontario. As you know, there were 30,200 Ontario physicians as of fiscal year 2015-16, including 14,100 general practitioners and 16,100 specialists. They are licensed in different ways and have different capacity, different training, and different ability to provide service.

The Ontario Health Insurance Plan, or OHIP, provides coverage for a wide range of health care services to more than 13 million eligible residents. Ontario makes payments in excess of $11.6 billion per year to physicians under OHIP, using both fee-for-service and non-fee-for-service or "blended" payment models, each of which has an associated accountability framework.

The conventional method of compensating physicians is to pay them on a transactional basis, a set fee for each service performed, known as fee-for-service payments. These eligible medical services and associated fees are found in OHIP's schedule of benefits for physician services. The schedule of benefits has over 7,000 fee codes and descriptions of service.

The ministry processes 184 million claims annually, representing about $7.9 billion of the total budget per year. About 96% of these claims, or more precisely 177 million claims representing $7.6 billion, are processed automatically after meeting a series of built-in checks and balances to ensure that the item is billed and eligible for payment. The 4% that do not meet these built-in controls are rejected for payment and are then manually reviewed by a claims assessor to ensure payment is appropriate.

Some of the checks and balances: Obviously, if a fee is submitted for a newborn examination in an 84-year-old patient, that will be rejected out of hand and will become part of the manual review process and subsequently returned to the physician. Compensation, apart from fee-for-service, is also provided through primary care funding models, which I'll provide more details on.

We've been working hard, over the last two or three years, to find the appropriate balance to ensure that our physicians are amongst the highest paid in Canada while also investing in important services to increase the quality of care and to ensure that services provided under our health insurance program are appropriate and high-quality services which meet scientific evidence requirements for providing benefit.

Jurisdictional scans, as well as scientific reviews and advice from expert panels, are embedded within our policy development processes. These are a key input that helps us to understand physician compensation literally around the world and to ensure that our activities are informed by the best evidence available.

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Since the mid-2000s, various changes in the physician payment landscape have occurred. In terms of post-payment accountability, an external review of the fee-for-service accountability framework—the Cory report referenced by the Auditor General—resulted in sweeping changes that have limited the ministry's legal authorities to investigate billing practices and recover funds that may have been billed inappropriately.

Before the Cory report, the ministry was able to directly recover overpayments, with no limitation on time periods of review or amounts recovered. The changes made as a result of the Cory report have restricted the ministry's ability to account for physician payments and to recover inappropriate payments in the post-payment period. We are essentially relying on the physician to bill appropriately through an honour system.

The ministry does have payment accountability processes and activities in place to ensure that physicians do not receive or retain totally inappropriate payments. In general, these activities can occur through either prepayment or post-payment mechanisms. Prepayment activities include monitoring and surveillance, such as data analytics and reporting, automated payment controls in the OHIP claim processing system, manual review of claims and, importantly, physician education as to billing appropriateness, and communication and training of physicians as to how to use the system properly.

Post-payment activities include targeted physician education and communication; post-payment reviews; formal physician audit, including review of medical records; voluntary repayments; and formal appeal processes for recoveries—although the Cory report did make all of these post-payment processes more cumbersome for the ministry to use in a nimble way.

Other Canadian jurisdictions have strong legislative authority to monitor and recover claims post-payment. Ontario has a fairly weak process as a result of the Cory report, and on an adjusted basis, Ontario recovers less inappropriate payments than do other provinces.

As mentioned, I'd like to provide you with some detailed information relevant to primary care models.

The ministry has worked hard over the last decade to ensure that Ontarians can have access to a family doctor when they need it. Part of the reforms introduced to ensure access to primary care included reforms to compensation of primary care that are now being followed by other provinces and probably serve as best practice to attract physicians to primary care practice.

Primary care reform was first introduced in 2003 to promote group-based practice, where several physicians share care for a group of patients, as well as comprehensive care, where longitudinal relationships with providers are encouraged in order to have a longitudinal understanding of the patient's health care needs and to expand the team-based model to providing care after hours, on weekends and on holidays, with access to patient information.

Prior to 2003, 98% of primary care physicians in Ontario were paid in a transactional fee-for-service practice. During that time, Ontarians faced a significant shortage of family physicians which left large numbers of patients—25% or more, even 30% to 40% in some regions of the province—without a primary care provider. The practice of family medicine was not financial-

ly sustainable for new graduate physicians, largely because of the fee-for-service model of compensation.

Primary care reform between 2003 and 2011 employed efforts to increase the number of family physicians in the province by increasing training positions and introducing the Northern Ontario School of Medicine, to encourage providers for the north to attach patients to a provider and to promote comprehensive care. This has resulted in the current experience that 94% of all Ontarians now report they have access to a family physician.

There are currently 8,800 primary care physicians in Ontario practising through one of the blended primary health care compensation models, providing care to over 10.5 million enrolled patients; 375 physicians practising in the comprehensive care model, serving 400,000 enrolled patients; 2,600 physicians working in family health groups, serving 3.2 million patients; family health networks representing 237 physicians and 230,000 patients; and 5,000 physicians working in the most common model, the so-called family health organization, serving over 6.5 million patients, as well as rural and northern physician group associations, which have enrolled 67,000 patients by 98 physicians.

A subgroup of the family health organization compensation model is represented by family health teams, which, in addition to physicians, include a host of interdisciplinary providers, providing care to 3.1 million Ontarians in 206 communities.

All of these models are focused on providing comprehensive primary care to all enrolled patients through a combination of regular office hours and after-hour services, based on alternate funding contracts.

In regard to responding to your questions today, I just want to mention some confidentiality items which may limit specific details being discussed, including sharing personal health information. As well, we report that the OMA negotiations team has been established to resume discussions, but we would of course not comment on those discussions in progress.

Moving now to progress in audit recommendations: As the Auditor General mentions in her report, physician compensation is complex. Our progress on the recommendations is as follows.

Recommendations 1 and 8 both relate to ensuring patient enrolment models are cost-effective. The ministry has largely finished an analysis of the current base rate capitation payment, identifying fee codes that should be in the common basket of services provided within the capitation model. Based on analysis, adjustments to the capitation rate require the ministry to engage with the Ontario Medical Association through the negotiations consultation process defined by our representation rights and joint negotiation and dispute resolution agreement with the Ontario Medical Association, but we now understand very well the elements that relate to the patient enrolment model and potential modifications, including review of the access bonus—including examination of the numbers of groups that have patients receiving services outside the enrolling group in excess of the access bonus and expenditures by the ministry.

Recommendation number 2, that patient enrolment models define indicators to measure quality of care, including specific targets that could be collected, published and regularly monitored to assess performance against target: We're working with Health Quality Ontario on this recommendation. Progress is being made to ensure that patients and the public have a clear understanding of how the health system performs through HQO's yearly report Measuring Up, again requiring the commitment of the Ontario Medical Association for modification of performance in response to indicators being published.

Recommendation number 3, on ensuring patients have timely access to their primary care provider, thereby reducing the strain on emergency departments in hospitals: We've looked at a policy contract review to evaluate whether the current enrolment models and contracts are sufficient to encourage better access for enrolled patients. We've virtually completed this policy contract review, as well as exploring options to further enhance monitoring by strengthening data available to the province, looking at existing survey tools and also looking at the rich source of information available from physician shadow billing, which determines whether physicians are indeed providing after-hours or weekend services.

We're looking at developing a group profile to share with physician groups as a means of educating them on their performance against their requirements and contracts.

Recommendation number 4 related to sharing patient records between physicians to ensure patients receive continuity of primary health care services. Through the Digital Health Strategy, the ministry has developed and implemented a number of digital health solutions to help physicians share records and improve care coordination, notably including the connected backbone, allowing information to be shared between primary care and hospital, and vice versa. Other examples include e-notification, where providers are notified when patients arrive in hospitals or emergency rooms, allowing primary care providers to understand services being provided to their patients.

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Recommendation number 5 was to minimize the number of visits to emergency departments for non-urgent care. In a proposal given to the OMA in December 2016, the province committed to providing additional support to family doctors and anticipating that this would provide them with extended hours of care. Additional supports to family doctors providing appropriate hours of care based on the needs of their rostered patients would need to be negotiated as part of a new physician services agreement. We continue to consider best practices in other jurisdictions to inform all of these.

Recommendation number 6 on understanding of variance in physician compensation, including obtaining physicians' operating costs and profit margins: We currently don't have the ability to collect this information without the co-operation of the Ontario Medical Association.

Recommendation number 7 on ensuring the access bonus paid to physicians has its intended use: We're reviewing the information received by the patient at the time of enrolment to consider further education processes for patients. We're also reviewing the access bonus, including an examination of the number of groups that have patients receiving services outside the enrolment group in excess of the access bonus and expenditures. This, again, would require further negotiation with the OMA to change the current primary care contracts.

Recommendation number 9 on ensuring health care dollars are spent only on medically necessary procedures: Health Quality Ontario has recently launched a quality standards program that will contribute to an understanding of appropriateness and quality of care.

Recommendation number 10 on strengthening oversight of fee-for-service: We've established a plan to increase, coordinate and realign staffing resources to monitor physician payments. Also, we're looking at investments in I&IT tools to monitor physician payments and evaluating the costs and benefits and, crucially, feasibility of amending the fee-for-service billing review process and re-establishing an inspector function.

Recommendation number 11 on reviewing the schedule of benefits to reflect current medical practice: This is something that we've invited the Ontario Medical Association to participate in. This, we anticipate, will form a framework as part of our negotiations.

Recommendation number 12 on strengthening oversight of the Cardiac Care Network and recovering $3.2 million of overpayment: As of January 2017, over 1,000 echocardiography facilities are registered. Foreign accreditation assessment is part of the Cardiac Care Network's process to look at oversight of diagnostic facilities for cardiology. With regard to recovery of the $3.2 million of overpayments identified by the auditor, we're currently reviewing our options under the Health Insurance Act to determine the appropriate course of action.

Recommendations 13 and 14 with regard to medical liability protection and especially ensuring that membership fees are not used for lawyers to assist physicians with billing reviews: We've retained former Justice Stephen Goudge to conduct the third-party review and provide a report with recommendations for the ministry—anticipating this in summer of 2017.

We thank you for giving an opportunity to us. In 20 minutes, it's hard to review the complexities of the physician billing system, but we appreciate this opportunity to discuss the recommendations.

The Chair (Mr. Ernie Hardeman): We accept the complexity. That's why I gave you an extra couple of minutes.

Dr. Bob Bell: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much, Deputy. With that, we will start with the questions and comments with the third party. Ms. Gélinas.

M^me^ France Gélinas: Good afternoon, Deputy, and thank you for coming to committee. I will start with some fairly broad questions from the auditor. We know from the auditor's work that physicians paid through FHO earn an annual gross revenue of $420,000; physicians paid through FHG get an annual revenue of $352,000; and physicians paid through fee-for-service, their average is $237,000. At the high level, are there explanations for the different levels of payments?

Dr. Bob Bell: The fee-for-service physicians that are earning an average of $237,000 are only primary care providers. Other fee-for-service physicians earn far in excess of that, as you know. There are a number of factors that go into this.

Full-time family physicians, over the last 10 years, have tended to move toward comprehensive care models, represented by FHNs, FHGs, FHOs and FHTs—the alphabet soup of the way that we characterize compensation for physicians. Physicians who remain in fee-for-service models are often part-time physicians who can't provide a comprehensive guarantee to a roster of patients that they'll be accessible. They may be in specialized practice environments, for example. Focused practice for general practitioners in sports medicine or providing psychotherapy would fit into this category, as well as physicians who focus on specialty practices; for example, in preventive medicine. There are a number of different features that result in the fee-for-service group having a more focused practice and having a lower expectation of compensation.

When we look at the comprehensive models, I think it's fair to say that we certainly have higher expectations of comprehensive, longitudinal care. We anticipate that physicians will organize themselves into groups that will share on-call coverage and out-of-hours service for patients and that they'll arrange a mechanism to share health records around longitudinal health issues. So the expectations for service are certainly higher in the rostered models than they are for physicians providing fee-for-service primary care.

M^me^ France Gélinas: There's still a significant difference between a FHO and a FHG. Although, the way you've described it, you've made it clear why the fee-for-service could be different, how can you explain the difference between the FHO and the FHG?

Dr. Bob Bell: The FHG model is based on a relatively small payment for the rostered services, the comprehensive services, with a bonus payment provided on a fee-for-service basis. The actual model encourages more transactional care for patients. We would see patients, perhaps, being offered fewer remote services—telephone services, in some cases, email services, as are offered in the comprehensive model family health organizations—that don't require a patient visit. The ways that patients can be educated to use services more appropriately—and not necessarily get services through face-to-face contact with physicians—are certainly found more commonly within the family health organization model. That provides the opportunity to earn more compensation without necessarily having the face-to-face contact with patients. The other issue is the expectations of comprehensive care, the basket of services they're being compensated

for. Comprehensive services in the FHO model are greater than in the FHG model.

M^me^ France Gélinas: From your understanding of how things work, do you think that we're getting value for money through the FHO?

Dr. Bob Bell: You know, I think that it's always possible to improve on the value for money achieved with all these models. Certainly, the journey of learning how to encourage comprehensive care through varying compensation models is one that is a process. I think it's fair to say the ministry has learned a lot from how we monitor performance in these models.

We know that probably in 50% of—when we do surveys of patients, we recognize that patients are utterly satisfied with their access to providers in FHO models and FHT models. We also understand that there is room for improvement in some of these models as well.

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Understanding how the ministry actually monitors performance is something that we've learned a lot about. I think, going forward, we'll be able to think about new ways to achieve better response.

M^me^ France Gélinas: Thank you for your response.

How would you reconcile the fact that the FHOs average $420,000 and your stats from your ministry show that they work an average of 3.4 days a week? The FHGs make $70,000 less on average, yet work, on average, four days a week. How do we reconcile those stats?

Dr. Bob Bell: We spent a lot of time talking to the OMA about that in a variety of venues, as you might imagine. One of the concerns that the Ontario Medical Association always offers is that our data may not reflect reality, in terms of the 3.7 days.

When we're talking about that, we're making use of what's called shadow billing data. The OMA would suggest, perhaps, and the Ontario college of family practice suggests that because of their concern about comprehensive care in a basket of services that FHO doctors are being paid for without having to concentrate on transactional billing, they're not always as accurate as they might be based on their shadow billing submissions.

The OMA often suggests that we don't have the full understanding of the times that services are offered in FHO models, whereas the family health groups, as you know, are compensated by both the smaller, comprehensive rostered payment and a bonus on top of certain fees, so they're highly incented to submit their billing data, as opposed to family health organization providers, who are submitting shadow bills that aren't as impactful on their compensation. That's something that we frequently hear from the Ontario Medical Association, and something that clearly needs work.

M^me^ France Gélinas: Is my area an outlier or is it similar elsewhere in Ontario, where most of the FHO physicians also run the biggest walk-in clinics? As in, they work, they have their 1,500 patients within their FHO, they work three days a week, and they work another three days a week in walk-ins, billing OHIP directly.

Dr. Bob Bell: It's difficult for us to identify walk-in clinics, to be absolutely straightforward. Walk-in clinics inevitably represent a blend of patient care models. For example, in the report produced by Dr. David Price, who is the chair of family medicine at McMaster, and Liz Baker, an experienced nurse practitioner working at a nurse practitioner-led clinic, they actually suggested that walk-in clinics were an effective method for comprehensive care physicians to provide care out-of-hours, on weekends and holidays.

We think that certainly in some walk-in models, there are patients being seen who are urgent-care rostered patients—as well as providing care on an urgent basis to non-rostered patients. We're reluctant to disincent these models in that we want to ensure that Ontarians have access to primary care.

We think that new arrivals in a community, who might first see a primary care provider within a walk-in clinic, are often encouraged to roster with the providers in that clinic, so actually separating out the patients within a walk-in clinic who are rostered and non-rostered can be complex. If a provider is seeing their rostered patients within a walk-in clinic environment where they're also seeing unrostered patients, they can't bill for the comprehensive services provided to their rostered patients. Simply changing the model of office they're working in, they can't bill extra for their rostered patients.

M^me^ France Gélinas: Do you know for a fact that they are not?

Dr. Bob Bell: I know for a fact—

M^me^ France Gélinas: How would you catch this?

Dr. Bob Bell: Yes, okay, that's a good question. How do we know for a fact that a patient who is rostered to a primary care provider within a group practice, seen by the same primary care provider within a walk-in clinic—so that the fees associated with that visit would be identified by the ministry as shadow billing fees, based on the association of the billing number and the OHIP number. If the physician tried to bill that as a minor assessment or an intermediate assessment, it would be rejected because that can't be billed as a fee-for-service claim. The billing number and the patient number would not allow that to happen. So we do know that for a fact.

M^me^ France Gélinas: When you say that you do some computer reviewing of a billing—so if a mistake was done where they actually billed for somebody who was on their roster, the computer system would automatically pick it out?

Dr. Bob Bell: Let me just check to make sure that's correct.

Interjection.

Dr. Bob Bell: That is correct.

M^me^ France Gélinas: Okay. Then it would be dealt with the way you've explained it to us—the 4% who actually get a phone call saying, "You have some explaining to do"?

Dr. Bob Bell: That's right. In fact, there is a remittance advice that's sent to physicians on a monthly basis electronically. This is all done now by electronic

submission; there are no paper forms. The remittance advice is sent back to the physician with certain rejection numbers on it. This code would explain that's a rostered patient not eligible for a fee-for-service transaction.

M^me^ France Gélinas: Do similar things happen when a rostered patient goes and sees somebody else? Do you know that a rostered patient has gone to see somebody else?

Dr. Bob Bell: If a rostered patient is seen by a member of the group—that's what we want to have happen—and we know that, because we know these billing numbers are associated with a group; they have a group number associated with them. Being seen by a member of that group is what we want to have happen with comprehensive care. Those doctors with those numbers all have access to the patient's longitudinal health record. That's a positive aspect of care.

If they're seen by a physician outside that group and we recognize that, that impacts the provider's access bonus. So 10% of fees are held back in our capitation models, and they're provided to the physician if their patients are only seen by themselves or members of their group.

M^me^ France Gélinas: I thought it was 20% that was held back. Is it 10%?

Dr. Bob Bell: It's 18% to 20%.

M^me^ France Gélinas: So it's 18% to 20% that you're allowed to hold back.

Dr. Bob Bell: Correct.

M^me^ France Gélinas: How much time do I have?

The Chair (Mr. Ernie Hardeman): About five minutes.

M^me^ France Gélinas: Okay. I'm going to move on to the after-hours requirement. The auditor tells us that 50% of FHOs did not meet their after-hours requirement and 36% of FHGs did not meet their after-hours requirement. That comes from your data. Is there a way to explain this?

Dr. Bob Bell: First of all, the requirement for after-hours coverage is complex, as the Auditor General points out. It's complex, and there's a risk of unintended consequences. In small, rural communities in the province, hospital coverage, obstetrical services, emergency coverage, is provided by primary care providers who are also in comprehensive models. Depending on how many of the physicians in that group are providing hospital services or emergency department services, the number of nights of coverage for that group will be reduced. So if 50% of the providers are providing services in the hospital, the number of nights may be reduced to—zero?

Interjection.

Dr. Bob Bell: Anyway, it's substantially reduced. The reason for that is, of course, that the doctors left behind in the practice—who are not providing hospital services or caring for the other doctors' patients. So we know that, and we're flexible with respect to that because if that group loses one doctor, the last thing we want to have happen is a small, rural hospital losing its coverage. So we interpret that with discretion; the other, with a degree of care.

The other issue that the Ontario Medical Association points out to us is, the data provided with respect to the family health organizations, as I mentioned earlier, should be interpreted with caution because physicians are not providing us with transactional bills; they're providing us with shadow bills. Because they are not being compensated as fully by those, they may not be as diligent in providing those bills.

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Obviously, we don't think that's an excuse. One of the goals of our discussions with the OMA has been to look at the relative balance of roster payments versus fee-for-service shadow billings: Should we change that ratio? Also, should we start reporting that information in a way that makes publicly available performance information?

These are issues that we think would improve performance in family health organization models. But, obviously, discussions need to occur with the Ontario Medical Association within our representation rights agreement.

M^me^ France Gélinas: So you're telling us that the 60% of FHOs that do not meet their after-hours requirement—okay, I'm trying to understand. If you already know that physicians within a FHO have hospital privileges and work in ER and obstetrics, wouldn't their requirement then be set? When we say that they don't meet their after-hours requirement, that comes after having taken into account what the requirement would be, would it not?

Dr. Bob Bell: The description, for example, in a group of five physicians who may have lost one of their physicians, where one of the physicians may have left the group, for after-hours services and service in the hospital—it's an active response that they have. Do we reach out and check? Yes, we do. Our ability to understand who is working in the hospital and how many hours they're working in the hospital depends on the honour system that we described in the fee-for-service transactional billing.

Are we constantly discussing with doctors their requirements, their responsibilities? Yes.

Is that a changing environment? That's what we hear from physicians. We're better now at monitoring performance. We've now got tremendous facility to look at the hours of service provision through our shadow billing service. Providing that information back to physicians, that's something that we do routinely.

Having primary care comprehensive contracts reflect a graded response to less-than-optimum performance is something that's really important for us. Currently, in the situation you describe, Madame Gélinas, our only response if performance targets are not being met is simply to terminate the contract.

We work on the basis of education, of discussion, of improving performance. That generally is effective. But quite often, we hear from physicians, "Well, your expectation of our service wasn't correct, so we forgot to bill

for those services. The shadow billing wasn't completed." That's one of the most frequently heard responses.

M^me^ France Gélinas: But with the FHGs, you've already told us that they are incented to really show their full billing so that they get their full pay. Still, 36% of them don't meet their after-hours requirement.

Dr. Bob Bell: And that's something that we're working on. You're absolutely right. We need to see improved performance in that regard, and we need to have contracts that allow us to have a graded response to performance, as opposed to the binary response to performance that we currently have. That's certainly a learning that we've achieved and that we would like to see represented in further primary care contracts—absolutely.

M^me^ France Gélinas: The full—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We go to the government caucus. Mr. Dong.

Mr. Han Dong: Thank you, Deputy, for the presentation and for sharing with us some important information from the ministry.

I was very pleased to hear in the House that the OMA and the government are back to the negotiation table. I'm very hopeful to see that an agreement can be reached, because it is so important to our health care system, which is a bedrock to the quality of life here in Ontario.

Just very quickly, can you share with us: Have the changes to funding for primary care improved the availability for Ontarians to find a primary care physician, and do you have any stats to share with us?

Dr. Bob Bell: Thank you for that question. I'm going to ask the director of our primary care branch to provide some information, Mr. Phil Graham.

Mr. Phil Graham: Thank you, Deputy, and thank you for the question. My name is Phil Graham. I'm director of the primary health care branch in the Ministry of Health and Long-Term Care.

To your question: There's a few ways in which we could say that the reforms in primary care in Ontario over the past decade have improved access. I think the deputy covered a couple of these in his opening remarks, and I'll highlight a couple of those and introduce a few new ones as well.

Certainly we've seen a significant increase over the past 10 or 15 years in the number of medical students choosing family medicine as their choice of specialty. In the early 2000s and the late 1990s, there was declining participation in family medicine for many reasons. One of them was that the models available for family physicians in Ontario were not seen as attractive both in terms of the remuneration, as well as the models themselves. So the predominant method of practice at that time, upon graduation from medical school, was for a family physician to set up practice as a solo practitioner, billing fee-for-service, which has its place certainly in the health care system but in many ways promotes volume, promotes transactional delivery—with many exceptions but, generally speaking, that's how it was regarded by many.

The introduction of new models tried to rectify that in many ways. One, as the auditor pointed out, the remuneration certainly increased, but not only that, the model of practice was significantly different. These new models included groups of three or more physicians working together in a collaborative practice, so that, on holidays, for complex patients, they could back each other up. It required what's called "patient enrolment," which secures formally a relationship between a patient and a physician, which is shown to improve health outcomes over time, as well as quality of care, as well as introduce requirements for electronic medical records and things that make practice easier.

That's one way that the practice models that family medicine graduates were entering into and the change that they saw actually allowed for more medical students to choose family medicine as their choice of practice. Some changes were made in terms of the funded positions in medical schools around that time as well to ensure that we had a stable supply of family doctors entering Ontario every year.

Another thing to say about the reforms made through the payment models was the type of care that these models promoted. As the deputy mentioned, the family health organization, the family health network and the other models promote comprehensiveness of care. It's less around billing a fee for a particular service, focused on a particular ailment or an injury; the focus is on comprehensive holistic care organized around the need of the person. That care generally includes prevention work, things like immunizations, cancer screening, health promotion, as well as chronic disease management, which are seen as important for an aging population.

These are quite different models of care than I think you would see in your typical fee-for-service environment because it allows, again, the group to work together in providing that cradle-to-grave service based on a comprehensive suite of services that are compensated for. As I mentioned, patient enrolment and that formal patient attachment is a critical feature in these models because it does secure that provider-patient relationship.

In terms of access, another thing about these models is the requirements for after-hours coverage, as well as weekend coverage. We respect the auditor pointing out that compliance with those requirements may be in question, and the deputy described some reasons for that, but many of the physicians are in some ways providing that extended access to their enrolled patients.

In addition to the advancements made in how doctors are compensated and the models within which they work, there were also some innovations over that period of time in the introduction of interprofessional models of primary care delivery, as well as the expansion of existing models.

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During this period, for example, family health teams were created in Ontario—200 family health teams were created across the province. That involves physicians in these comprehensive care models working alongside

nurses, nurse practitioners, social workers, dietitians and pharmacists to make sure those patients can access a range of services so the physicians can focus their efforts on those patients that are most complex, as well as those complex patients having the benefit of pharmacy support, social work, mental health and things of that nature.

Family health teams are one new model introduced during that period, but community health centres—a very important feature in the primary care landscape, with their focus on those with barriers to access and the social determinants of health—were also expanded during that time. These provided opportunities for physicians to expand their reach for patients and for patients to benefit not only from the comprehensiveness of the new models of physician remuneration but also from the interprofessional supports that were required and needed for patients in terms of addressing chronic care, addressing mental health needs and other wraparound supports required.

I think another advancement during this period was also the introduction of models of delivery, including physicians, but exclusively to focus on those unique and more high-need regions. We've talked a lot—and the auditor's report talked a lot—about the family health organization, the family health group and the family health network, which are the models that have the most physicians that are participating.

There are also models such as the Rural and Northern Physician Group Agreement, or the RNPGA, which is a remuneration model and a practice model unique to rural and northern areas to acknowledge the unique circumstances that they have in terms of recruiting physicians, in terms of the small communities that they generally serve, and how that may not be conducive to, for example, the fee-for-service model or some of the other models. We have a number of physicians who have entered that model and have actually changed for the better many of these rural communities that have had perpetual challenges in recruiting doctors to serve those communities.

For indigenous health, we also worked with the Ontario Medical Association on the Sioux Lookout agreement, a unique agreement for the Sioux Lookout region, a region that has had perpetual challenges in recruiting physicians. As we know, there are many fly-in communities associated with that region, and geography poses a particular challenge. We were able to design, with the OMA, a particular model for physicians in that region to make sure the residents of Sioux Lookout are receiving the primary care that they need.

The same as well for the Weeneebayko Area Health Authority: a unique agreement to address the needs of that particular community and communities.

We also have aboriginal health access centres. There are 10 across the province, serving up to 100,000 members of indigenous communities. It's a unique funding arrangement for physicians who work in that model, again, to take the emphasis off fee-for-service and put it more on comprehensive care, addressing the unique needs of the indigenous clients served in that model.

More recently, we have really looked at focusing entrance into the FHO and the FHN model in particular, two areas of high need. We understand the compensation differential between those models and the other models, and the ministry has put an effort into ensuring that, if that amount of funds are being expended for those models, they are being directed into those areas of the province that need them most. Right now, entrance into these models is focused on those communities that are in more need of physician services than others. Although it doesn't involve a change to the actual model that has been in place for 10 years, it does involve a change of where physicians enter those models and the types of regions of the province where we're supporting in that regard.

Dr. Bob Bell: Speak to the unattached patients before these changes were introduced and the number of unattached patients we have today.

Mr. Phil Graham: Sure. In terms of the statistics, we've been running what's called the Health Care Experience Survey. This is a survey run annually of about 11,000 Ontarians to gauge their experience with the health care system, with the focus on primary care. The current rate of attachment is 94%. Although stabilized for the last few years, we've seen a considerable increase in the number of attached Ontarians over the period of 10 to 15 years, which shows a significant improvement, due in part, I think, to the introduction of these models, reforms in the medical school system, and the introduction of interprofessional teams. The 94% number is seen across the country as Ontario is a leading jurisdiction.

Those are some of the statistics that we can share about where we are in terms of improving patient access.

Dr. Bob Bell: In addition to the actual number of attached patients, the number of unattached patients is being reduced.

The other thing we've asked Health Quality Ontario and Cancer Care Ontario to look at is the quality of care being provided by comprehensive models, especially around the issue of services that increase wellness and health; for example, cancer screening and diabetes screening programs. When we compare the proportion of people screened for colorectal cancer, breast cancer, cervical cancer or diabetes in the comprehensive models versus the fee-for-service type of models or the less comprehensive models, there is a substantial difference in the quality of care provided by the family health organization. Family health teams have a far higher proportion of their patients undergo appropriate health promotion services and screening services.

Mr. Han Dong: That's great. When I heard you saying "high-need communities," I couldn't help but think that my own riding, Trinity–Spadina, has seen unprecedented growth in the condo communities. These are the areas that we need to look out for, for whether or not they have access to primary care. That's very important to me personally but has less to do with the committee today.

How much time do I have, Chair?

The Chair (Mr. Ernie Hardeman): How much time? You have about seven minutes.

Mr. Han Dong: Okay. Because the government introduced the Patients First Act, I want to know how this act has contributed to primary care models and patient access.

Mr. Phil Graham: Sure. Thank you for the question. The Patients First Act, as the committee will know, was passed by the Legislature in December 2016. The development of that legislation and the overall strategy included fairly far-reaching consultations with patients and with providers across the province. Beginning in about December 2015, we engaged in a broad consultation path. Over the period, I think about 6,000 individuals and groups were engaged, to get their ideas on how to improve health care in Ontario. We received about 200 formal submissions from our partners in the health care system—all the associations representing provider groups, patients and health care organizations. That was the genesis, by and large, for the Patients First Act that was introduced.

There are many parts of that legislation. There are four key themes in it. One is expanding the mandate of our local health integration networks to be that single point of regional accountability for health system planning and performance improvement, using what we call LHIN sub-regions—smaller, more granular geographies within the LHIN geography—to hone in and really discharge that broader role—

Mr. Randy Hillier: Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Randy Hillier: I know that we're focusing on the Auditor General's report. This line of questioning about a piece of legislation in the Legislature that has no relevance to the Auditor General's report would be out of order, I think.

The Chair (Mr. Ernie Hardeman): I would advise the member that it is the physician billing section of the auditor's report, and if the member could get to that.

Mr. Han Dong: Right. My question was, how did the act impact primary care models? It does have relevance—

Interjections.

The Chair (Mr. Ernie Hardeman): Well, we're not looking for an argument. Just carry on, and make sure you stick to the topic.

Mr. Han Dong: Well, you heard the Chair—

Mr. Jeff Yurek: Chair? Just quickly, Bill 41 hasn't really been implemented in the province—

Mr. Han Dong: Excuse me, Chair. Is that another point of order? Because my time is ticking.

The Chair (Mr. Ernie Hardeman): Is that a new point of order?

Mr. Jeff Yurek: It's a new point of order.

The Chair (Mr. Ernie Hardeman): Okay, let's hear the point of order.

Mr. Jeff Yurek: Bill 41, which has just recently passed, has yet to even begin implementation across the province. Maybe subsections have started. I don't know how this line of testimony, compared to the Auditor General's report, has anything to do with—

The Chair (Mr. Ernie Hardeman): I think it is the same point of order. We have advised the member to make sure he sticks to the auditor's report in the questioning.

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Mr. Han Dong: Well, you heard the Chair, so let's stick to the report.

Carry on with your answer, please.

The Chair (Mr. Ernie Hardeman): Carry on.

Mr. Phil Graham: Maybe I will skip the background of the piece of legislation.

I think there is a role, going forward, upon full implementation of the act and the broader strategy, for LHINs, local health integration networks, to take on a broader role as it relates to primary care; certainly, a broader planning role. Explicitly in the mandate, in the objectives of the LHIN, there's an explicit reference to the LHIN's role in primary care planning, including planning for physician resources.

Although it is still early days, I think there are a few ways in which, as this strategy rolls out over time, we will see improvements in the sector. Certainly, at the planning level, the introduction of LHIN sub-regions, a more granular level of focus for regional system planning, will better equip LHINs to precisely identify local need as it relates to access and as it relates to quality of care.

The sub-regions themselves—there are about 76 across the province. The average population size is about 150,000. Compared to the population size of a broader LHIN geography, which ranges between one million to two million people, you can see how focusing on that relatively smaller population allows for more precision in the identification of population need and the extent to which the primary care sector is meeting that need.

In some areas beyond sub-region planning, we know—for example, in heavily urban areas—there's a need to drill down at the neighbourhood level, given the density of population. Over time, we will increasingly see LHINs have that more granular focus. Things like access to primary care after hours and the use of emergency departments, those observations and those trends will vary community by community due to patient behaviour and due to the number of providers and the types of services those providers are offering. Again, that more precise level of analysis will allow LHINs to work with the ministry, local providers and patients to identify the root causes of some of those issues and to work within the community to address some of those issues.

Certainly, better integration is another goal of the broader strategy. We talk a lot about primary care access, but again I think, from a patient's perspective, their experience—

The Chair (Mr. Ernie Hardeman): If I could stop you there. You are not going in the direction of the topic of today. When we're talking about general planning, it will be impossible for committee to have an order in

order to put your presentation into our report because it would be out of order; it's not part of the auditor's report. So I would ask both the answerer and the questioner to stay to the topic of the auditor's report.

Mr. Han Dong: Let's move on to my next question then. We heard in the House today, and earlier in the briefing, about wait times. Can you give us a sense of what the ministry is doing with wait times in the province?

Dr. Bob Bell: I'll perhaps address this. Ontario was the first province to really focus on establishing accurate information for wait times. More than 10 years ago now, the development of access to care information technology services at Cancer Care Ontario really led the country in accurate measurement of priority services.

As was reported by CIHI yesterday, Ontario maintains its leadership position amongst the provinces in terms of the proportion of patients receiving total hip arthroplasty within the recommended period of time for that service. Within patients who are recommended to undergo CT scans and MRI scans, Ontario again is the leading jurisdiction. In terms of the amount of time it takes patients—

The Chair (Mr. Ernie Hardeman): We thank you very much for that. Your time has now expired.

Dr. Bob Bell: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): We will now go to the official opposition.

Before we do, again, I want to just point out the importance of spending our time in the committee to talk about things that are relevant to this section of the auditor's report. Anything else is great conversation, but we cannot use it as we deliberate about what we're going to put in our report because it would be out of order.

With that, we'll go to the official opposition.

Mr. Randy Hillier: Thank you for being here today. I listened intently to your presentation. I was assuaged by some of what I've heard.

You mentioned that the ministry has limited or even no legal authority to recover inappropriate billings, that both the OMA and the ministry don't believe the data that you're using to analyze and evaluate your systems with—the quote I have here is that "the data doesn't reflect reality"—and also that, although you have a contractual agreement with the physicians, you rely on an honour system.

Listening to these statements, one could conclude that the ministry is on autopilot or on cruise control when it comes to physician billing here: relying on an honour system, having no legal recourse to recover, and not having any belief or confidence in the data that you are analyzing. You mentioned that you have made substantial progress, and you went through all the recommendations. I heard the words "evaluation," "considering" and "looking at." How can you make any progress if you don't have any certainty in the data that you're evaluating?

Dr. Bob Bell: Thanks for those questions. There are several questions in there that I'll try and unpack. The first question related to the ministry's ability to recover billings that are thought to be inappropriate. This relates, as mentioned in our presentation, to the recommendations of Justice Cory. We do indeed have an ability to recover, from a physician, voluntary recoveries. The physician agrees to—

Mr. Randy Hillier: You would have no legal authority. There may be a voluntary ability, but you said that you have limited or no legal authority. That has been since the mid-2000s. Has the ministry not done anything to address that huge failing?

Dr. Bob Bell: The process that we have under law is to refer cases of recovery to the Physician Payment Review Board. Indeed, we do that.

However, the process for investigation suggested by Justice Cory makes it difficult for the ministry to respond in a nimble way. It's required that the ministry evaluate each individual bill submitted for evidence of appropriateness. This requires that the ministry ask physicians to provide photocopied records from their files as to each service provided. We then need to have medical experts review each one of those records from the physician's office and determine whether each individual bill was appropriate.

Mr. Randy Hillier: You also mentioned, though, and we've seen in the evidence, that the recoveries are getting less and less. But when we take a look at the other data in the Auditor General's report, it doesn't suggest for a moment that it's because of reaching perfection in the system. It's quite the contrary; the recoveries are getting less and less.

You stated in your presentation that, unlike all other jurisdictions in this country, they do have greater legal authorities. Why has the Ontario Ministry of Health not acted upon that failing over 10 or 12 years?

Dr. Bob Bell: The suggestions that were adopted from Justice Cory's review of our inspection process and our review process for potentially inappropriate billings were put in place 10 years ago, as you suggest.

What we've seen in that time is the difficulty without inspection rights: We're unable to go into physicians' offices and review a large number of files—rather having to reach out to physicians and suggesting that they submit photocopies of records of services provided. As you might imagine, it takes a long time to get physicians to comply in that way. I think what we've seen over the past 10 years is that, indeed, as you suggest, there are difficulties with our post-payment accountability processes.

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The ministry is currently looking at a number of different recommendations, including re-establishing an inspectorate within the post-payment accountability division of the ministry; getting the ability to move into offices and actually inspect records en masse rather than asking for individual records to be provided to us; and also asking for repayment of potentially inappropriate funds as a starting point rather than having to go through a process of review by the Physician Payment Review Board.

Mr. Randy Hillier: I have to question why we have a contractual arrangement if neither of the parties can agree on the data or the services, and they're only relying on an honour system.

Dr. Bob Bell: That moves on to the question of the physician services agreement that we have—not post-payment accountability but, rather, the provision of services by physicians under the physician services agreement, under the primary care contracts that we have.

I want to emphasize that the vast majority of physicians bill entirely appropriately—

Mr. Randy Hillier: I'm sure they do.

Dr. Bob Bell: —and the vast majority of primary care providers are entirely accountable for the contractual obligations.

Mr. Randy Hillier: Well, under this system, it would be just total chaos if they didn't, because there is no oversight. So it would be absolute chaos.

Dr. Bob Bell: There is oversight. For example, we mentioned that 96% of fees are paid immediately. Some 4% are rejected by our information technology resources, and they are subject to subsequent review. For services that appear to be inappropriate, certainly those are reviewed; that's part of the 4%.

Physicians have a professional obligation to bill appropriately. It's part of their professional responsibilities.

Mr. Randy Hillier: Let me ask one further question before I turn it over to my colleague. We see transactional records from every sort of industry throughout the land. Visa does multi-millions of transactions each day; they seem to get it pretty good. It's the same with debit cards and everybody else. Has the ministry looked at actually having a transactional record at the point of sale, at the point of transaction, between the patient and the provider, so that there is an actual transactional record, not this shadow billing or not this data that is uncertain or can't be relied on? To me, this seems like it would be a no-brainer. Every other transaction in the world happens with a documented record at the point of sale.

Dr. Bob Bell: Indeed, there is a documented record at the point of sale, in that part of the service that we are paying for—

Mr. Randy Hillier: But one of the parties doesn't have any record of it.

Dr. Bob Bell: We are certainly capable of asking the physician to provide us with a copy of that record if there's concern about the veracity of the bill.

Mr. Randy Hillier: But the patient doesn't have any record of it.

Dr. Bob Bell: The records made in any patient encounter—the intellectual property of that record belongs to the patient, so any patient can get access to their records at any time.

Mr. Randy Hillier: It's just not provided at the time.

I'm going to pass it over to my colleague here.

Ms. Lisa MacLeod: Thank you, Randy.

Thank you very much for coming in today, Bob.

I want to just move on to where my colleague France Gélinas was in the middle of her questioning, which was with respect to walk-in clinics and the inability of the ministry to reconcile where those 40% of enrolled patients are going, in terms of walk-in clinics.

I was quite surprised that your own billing system indicates that about 40% of enrolled patients went to walk-in clinics or other family physicians outside the group with which they were enrolled in 2015 and, further, that your own survey from October 2014 to September 2015 showed that approximately 30% of Ontarians had visited walk-in clinics in the last 12 months. I'm guilty; I've done it myself. But the ministry hasn't required physicians to share the patient records between walk-in clinics and family physician practices.

I have a couple of questions around that. The first is, with respect to outside care and the use of walk-in clinics, can you clarify why the ministry is unable to identify which physicians are operating a walk-in clinic?

Dr. Bob Bell: Well, the concept of walk-in clinics, realistically, is nomenclature that's applied by the public and by providers in the system. There's no registry required for a walk-in clinic.

Why is that the case? As I mentioned to Madame Gélinas earlier, walk-in clinics can provide superb comprehensive care, as recommended by Price and Baker. In the centre of Hamilton, for example, the family health team in Hamilton operates a walk-in clinic. Patients who are rostered to that family health team can walk in during the hours that the walk-in clinic is open and get comprehensive care for urgent conditions by the group of physicians who work in that family health team without an appointment.

The Halton Hills Family Health Team, which is located across seven different locations in the Georgetown area, has a single clinic that serves as a walk-in clinic after-hours and on weekends. Physicians in those multiple groups take turns at being in that clinic, where they see patients without an appointment.

The key characteristic of a walk-in clinic is simply that no appointment is required. It doesn't refer to the rostering model. It doesn't refer to whether or not you're a member of that group. In many walk-in clinics, we encourage this kind of care: that after-hours, if you have an urgent health situation, your provider group will be available to you on a walk-in basis.

We also want Ontarians to have a choice as to how they achieve care, so those walk-in clinics, if they're the sole resource in the community to provide random care to patients if patients are not yet rostered—they've just moved into a community, they're visiting etc.—quite often those providers operating the walk-in clinic for the benefit of their rostered patients will also see non-rostered patients. In the case of new patients to a community, this is frequently one of the ways that people become rostered: They try out a couple of different walk-in clinics, and they roster with the physician they find compatible.

Ms. Lisa MacLeod: That gives me an opportunity, then, to congratulate my local health team, the Greenbelt

Family Health Team. They actually share the same strip mall that I'm in, and they're doing great work.

Dr. Bob Bell: Terrific.

Ms. Lisa MacLeod: I think—if I could sort of go off-script—that they do need another physician there, and I've written to the Minister of Health, so if you would like to help me with that, that would be fantastic.

Dr. Bob Bell: Thank you. Mr. Graham is taking that down, I promise you.

Ms. Lisa MacLeod: Excellent. That's fantastic.

But one of the things that concerns me almost goes back to this notion around eHealth and patient records. For example, if I go to visit my family physician, who is Margaret Deutsch, and then the following week I have an issue after-hours and I happen to walk into an Appletree medical clinic—I don't think that Ontarians, and patients in particular, feel satisfied or even comfortable that their health records are being shared among the two.

I guess the question that I would have in follow-up to this discussion that we're having is: Can the ministry explain how its Patients First strategy improves co-ordination of care for patients receiving care from more than one physician?

For example, in Ottawa, my husband was recently diagnosed with a concussion. He would go to the Queensway Carleton Hospital—that's where we had to go immediately—and then follow up with his doctor. The onus is sort of on the patient to take that. How have we advanced, given some of the challenges that we faced with eHealth?

Dr. Bob Bell: There's a program that started in—

Ms. Lisa MacLeod: You did notice that I got all my hospitals and health units in there.

Laughter.

Dr. Bob Bell: And it was Greenbelt Family Health Team?

Ms. Lisa MacLeod: Yes.

Dr. Bob Bell: Phil, make sure you get that down.

The approach that we're taking to solve the real problem faced by your husband—that is, getting episodic care for an urgent condition in an emergency department, then wanting those records—that problem is technically solved by a program called Hospital Report Manager. It's gradually spreading across the province. It's present in southwestern Ontario and the GTA, and on its way to Ottawa.

Basically, PDF reports from hospital discharge summaries, consultant reports and emergency department reports are not only sent to registered primary care providers, but actually embed themselves inside the health record. They're not just an appendage to the health record; they'd actually be stored under your husband's OHIP identification within the record. This is a terrific resource that will be spread across the province probably in the next 18 months.

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The other thing that will be coming to a hospital near you is something called e-notification, present in about half the hospitals across the province. When a patient is registered in an emergency department, the so-called ADT system—admission, discharge, transfer system—of the hospital recognizes that patient is a member of a family health team, a comprehensive care team, and will actually notify that comprehensive care team, with a message that pops up on the next opening of the electronic medical record, that a visit was made to an emergency department.

We utterly agree with you that comprehensive care requires these automatic elements of notification, and they are on the way.

Ms. Lisa MacLeod: And just one final question, because we are talking about emergency rooms: The auditor, in her recommendation 5, made a series of recommendations to minimize the number of patient visits to the ER for non-urgent care that could be provided in a primary care setting. She suggested that your department should evaluate whether the existing after-hours services offered by the contracted physicians are sufficient for their enrolled patients to obtain non-urgent care and better educate patients on the most appropriate place for non-urgent care when their family physician is not available and consider best practices from other jurisdictions such as ensuring that after-hours care is easily accessible for patients within their communities. That might be a bit more difficult, I understand, in rural communities compared to urban settings like I live in.

In your initial response to the auditor, you agreed to evaluate existing after-hours services offered by contracted physicians and to review existing communication strategies for educating patients on options for non-urgent care.

I have been to ERs. We've seen that when they're overcrowded there is a problem with respect to ensuring that there is enough space available for surgeries. For example, at the Queensway Carleton Hospital, the day I brought my husband, Joe, in for his concussion, seven surgeries were cancelled. So there is an impact.

Finally, you agreed to conduct a review of best practices from other jurisdictions on access after regular business hours.

I know that's a lot to throw at you, but I'm just wondering: What is the status of all of those commitments that the ministry has made to the auditor, but, also, through her to us?

Dr. Bob Bell: At the first stage, relating to the presence of contracted physician services being available after hours and on weekends, we do have a much better way of measuring that now than we had previously. This is through assessment of shadow billing and education to family health organizations—and, to a lesser extent, to family health groups—about the critical reliance that we make on shadow billings to understand whether services are being provided after hours and on weekends. That's certainly one element.

The other element is the desire of Ontarians to achieve care in emergency departments. Talking to comprehensive care providers, they'll say, "We had space available for patients but we had three of our patients go to the

emergency department for conditions that could have been managed here." There's no question that when emergency department overcrowding occurs, it can be a real problem for both the hospital and patients in the emergency department.

It's also true that activity in our emergency departments goes up by about 6% per year, even though services are increasingly available in primary care. Ontarians want to get services in emergency departments. Ontario's emergency departments now, for low-acuity patients, provide care within four hours more than 90% of the time. That comprehensive, urgent care—with a CT, if necessary, a throat swab or a blood test—is something that Ontarians have come to appreciate.

We have a challenge in educating Ontarians about the importance of comprehensive care. At the same time, Hospital Report Manager e-notification, letting primary care providers know about the fact that their patient was in the emergency department, does represent comprehensive care.

In the evolution of our health care system, we certainly believe that patient choice is primary. We need to think about education, for sure, but we also need to think about how Ontarians tell us they want to use the system by their actions. Ontario's emergency departments are among the most efficient in the world. Patients who are being admitted to hospital are the patients who cause the overcrowding problems.

Ms. Lisa MacLeod: Do you think too—I mean, when I was first elected—

The Chair (Mr. Ernie Hardeman): Order. Your time has expired. Thank you very much. We will now go to the second round. It will be 16 minutes per caucus.

Before we start the round, I want to again express the opinion that we do want to make sure we stick to the questions as they relate to the auditor's report dealing with the billings. I want to say that on the last one, they did get back to that, and that is the intent of this meeting today.

With that, we go to the third party. Ms. Gélinas.

M^me^ France Gélinas: Thank you, Deputy. I will follow up on—you sort of explained to me the role that walk-ins can play. Let's look at emergency department visits for non-urgent care that could have been provided. The Auditor General tells us that for 243,000 visits, your ministry estimates the cost of this to be about $62 million, and then the part that's really weird is that $33 million of that is for patients enrolled in family health organizations. We just had Mr. Graham go through the FHOs and the FHGs that were put into place for chronic disease management to attach patients, and then you see that although family health organizations only have about 25% of Ontario's patients, their patients are the highest users of emergency departments for non-urgent care. How do we reconcile that?

Dr. Bob Bell: First of all, I'd say that $33 million—probably about 1% of the total fees paid for capitation models across the province. We're still talking about most primary care providers providing comprehensive care, including access to care for low-acuity conditions after hours within their offices.

There's no question that we believe the literature supports, and the world is moving towards, an understanding that comprehensive primary care is the best way to provide for the health of a population. The Canadian college of family practice and the Ontario college of family practice support a model that's called family-centred comprehensive care, "the patient-centred medical home." That really speaks to the importance of providing this longitudinal care model.

Now, you're absolutely right: We can improve. I think discussions with the Ontario college of family medicine and discussions with the Ontario Medical Association recognize that the performance of this comprehensive care model and the improvement of access to after-hours care is an essential element of providing excellent care for Ontarians. We need to improve it. However, at the same time, as I mentioned earlier, if we look at the performance of comprehensive models versus fee-for-service transactional models—and focusing on issues like diabetes screening, focusing on issues of cancer screening—there's tremendous evidence that these comprehensive care models improve the long-term health of Ontarians.

I think what it's fair to say is that the ministry recognizes, the college recognizes and the medical association recognizes that we can all do a better job of making access available after hours, on weekends, but we should also recognize the tremendous benefits in terms of patient rostering, in terms of access to preventive care—the holistic care that Mr. Graham was talking about that comes to Ontarians through these comprehensive care models. We think this is part of the process.

If we look across the country, other provinces are moving towards these comprehensive roster models. Alberta has recognized that that's a goal for its health care system. British Columbia—

M^me^ France Gélinas: Sorry. You're preaching to the choir, so I will go back with some of the questions in the Auditor General—

Dr. Bob Bell: Absolutely.

M^me^ France Gélinas: An entire part of the Auditor General's report shows us physician payments, so I'll take the first one on the list, the ophthalmologists: median gross payment $552,000; 90th percentile, $1.3 million—with a difference between the median and the 90th percentile at $713,000. Is there any way to explain those differences?

1400

Dr. Bob Bell: Well, I think we're talking about the standard deviation of professional practice within the transactional billing model. Certainly, if you look at the root causes of why some ophthalmologists bill at a higher level than the median, it relates to the organization of their practice, it relates to individual access to operating time, and it relates to the efficiency of their procedures for seeing patients and providing interventional services. There is quite a difference.

For example, the report of the vision task force chaired by Dr. Phil Hooper, the chair of ophthalmology at the University of Western Ontario, looked at the variability in the number of cataract operations, the most common operation provided by ophthalmologists, and found tremendous variation in the numbers of cases being accomplished. That was largely based, of course, on the amount of operating time available to those ophthalmologists and the efficiency with which they were able to provide a procedure.

So when we look at the specialities that have a high standard deviation, a broad curve around the median of income, we're simply looking at the variability of practice and the access to interventional resources. This is probably the major determinant that goes into these large differences in compensation.

M^me^ France Gélinas: How do you reconcile this with radiologists?

Dr. Bob Bell: Well, I reconcile it in the same way. Radiologists have access to different facilities. For example, a radiologist working in a hospital would have—the major place we do CTs and MRIs in the province is within hospitals. So for a radiologist working in a hospital, they would be perhaps undertaking interpretation of far more MRIs and CT scans. I think it's fair to say for my radiology colleagues, knowing their practice, that higher-earning radiologists tend to have a lot of CT and MRI interpretations in their practice.

So the variability of income depends on how many images the radiologist is interpreting and also the type of image they're interpreting. It again goes to the type of practice that they are pursuing and the resources available for them in undertaking services on behalf of patients.

M^me^ France Gélinas: All right. The auditor talks about the California model where doctors, ophthalmologists in that particular case, have gone on salary. This is a model that has been put forward as best practice. Has Ontario looked at that at all?

Dr. Bob Bell: Well, we had been talking earlier about the blended compensation models available for primary care. We think that the introduction of those blended models has had a huge impact in improving Ontarians' satisfaction with access to primary care. I've talked about the way those blended models influence performance in cancer screening and diabetes screening etc. I won't bore you by going through that again.

I know that Ontario leads the country in offering a variety of different models for physicians. If we look at the services that are currently provided under transactional fee-for-service billing models, again we have blended models of compensation. We all remember the days when we didn't have enough oncologists in the province, for example. We didn't have enough radiation oncologists, surgical oncologists, gynecological oncologists, medical oncologists. Today, Ontario is extremely well resourced with cancer specialists, and part of the reason for that is, we have a highly inventive model of alternate payment plans that provide compensation to oncologists based on the numbers of patients they see—

M^me^ France Gélinas: Any of them paid on salary solely?

Dr. Bob Bell: These models are akin to salary in that they will provide an FTE compensation pool, and groups of oncologists, for example—as you know, I know this very well, being a cancer surgeon. We would actually divide up the experience that each one of the providers would provide—how many days of research, how many days of teaching, how many services being provided, how many patients looked after—and that would determine my FTE compensation requirement. That certainly stabilized dramatically cancer surgery and radiation oncology in the province.

If we look at some of the other models, like the emergency department alternate payment plan, you remember the bad old days when—

M^me^ France Gélinas: Yes, and I have my little timer in front of me. I have more questions to ask you; I don't want to be impolite or rude.

Dr. Bob Bell: If I can just conclude, we think that Ontario leads the country in introduction of novel compensation models that enhance provider satisfaction and access to care.

M^me^ France Gélinas: Okay. The question is, you will remember through the Auditor General—she talks about the $40 million as an interim modifier to all patient enrolment physicians who treated high-needs patients enrolled in their practice. Of this $40 million, $17.4 million was paid to 3,400 physicians who should not have received this payment. What happened there?

Dr. Bob Bell: I'm just going to consult with my colleagues to make sure I give you the best answer possible.

M^me^ France Gélinas: Sure.

Interjections.

Dr. Bob Bell: I think everybody has about the same memory of it that I do, that we assessed the impact of that model—that is, were we seeing recruitment of patients with complex conditions and seeing subsequent improvement of their utilization of the health care system in a variety of ways? We found the model was not effective in providing comprehensive care to complex patients, and we discontinued the fee.

M^me^ France Gélinas: How about the $17.4 million that was paid to those 3,400 physicians? Are we ever going to get our money back?

Dr. Bob Bell: Listen, those patients received service. It wasn't that they—

M^me^ France Gélinas: So that's a no, we're not going to see our money back.

Dr. Bob Bell: We wouldn't recover funds from physicians who have provided service appropriately to patients. I think it's fair to say that we need to look at changes to the way we compensate physicians and evaluate the impact those changes have. If things don't work out as well as we expect them to work out, we certainly wouldn't take the funding back from physicians, but we might discontinue the model.

M^me^ France Gélinas: We also saw that in 2015-16, the ministry recovered $243,000 from 14 physicians from

the fee-for-service payment. Do you think that there are more than 14 physicians who could have billed incorrectly, or is the 14—

Dr. Bob Bell: I think it's fair to say that the Auditor General has pointed out that post-payment accountability is part of the health insurance system in Ontario that needs review, that needs to be considered for improvement. We agree with that, and we're looking at a variety of different options, including returning an inspector function to the ministry, including potential options for changing the way that we're able to get access to medical records to determine whether or not appropriate service has been rendered. I think it's fair to say the answer to your question is that we think we can do a better job and we're considering ways to do that.

M^me^ France Gélinas: There was also the status of the $3.2 million in overpayments to physicians related to cardiac rhythm monitoring tests that were inappropriately claimed. Have we got our $3.2 million back?

Dr. Bob Bell: We're looking at ways that we can address this within the Health Insurance Act provisions that we have. If we turn to page 585 of the Auditor General's report, there is a process for fee-for-service billing review. Evaluation of those billings was undertaken using the algorithm that's presented there. We then went through the educational process that is required under the recommendations made by Justice Cory to describe to physicians their obligations to ensure that billing is appropriate. Subsequently, physicians stopped billing these fees.

To this date, we have not recovered the $3.2 million, and we're considering whether we have options to do that.

M^me^ France Gélinas: So you're not even sure that we have options?

The Chair (Mr. Ernie Hardeman): Thank you—

M^me^ France Gélinas: No, no, no. I still have a minute and a half.

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The Chair (Mr. Ernie Hardeman): Well, I have it here that it says it's supposed to be done at 2:11. I'll give you a minute and a half.

M^me^ France Gélinas: You'll give me a minute and a half? Now you made me lose my train of thought.

We haven't recovered. We're hoping that we're going to be able to do something. You don't have to answer my last question. The changes in schedule 4, Bill 87, is this in part to give you the possibility to do that?

Dr. Bob Bell: You know I can't really answer that. I'm prepped for the Auditor General's report, Ms. Gélinas. I'm not really ready to respond to that.

M^me^ France Gélinas: Fair enough. Thank you.

The Chair (Mr. Ernie Hardeman): We'll now go to the government. Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today, Deputy Bell. It's good to see you again. I'm sorry I missed the first part of the meeting. I had another obligation. I'm glad you're here, and I won't mention taking them to the peas again today. We'll have a question that's related to that. I'm really glad to see that the Hospital Report Manager and that e-notification is happening.

My in-laws are part of a family health team. I'm part of a family health team. I'm with them at their appointments. That's happening at the Ottawa Hospital. It's an academic family health team, so that notification is much more direct right now because they can work within the hospital system, and it's critical to me because I've been to emerg three times with my father-in-law for a couple of different conditions simply because it was 8 o'clock on a Saturday night and the acuity was something that was like, "Well, we can't leave this till Monday morning."

When we look at those visits—I take to heart that those visits are something that the consumer wants. They think that's the right measure for them; it's immediate. They look at what they think the acuity they have is, so they go to emerg. It's really a hard thing to—it's kind of a cultural change.

Now having said that, in terms of compliance with those after-hours contractual obligations, what is the ministry doing in regard to that or what are we considering doing?

Dr. Bob Bell: Thanks, Mr. Fraser. I'm perhaps going to ask David Clarke, the director of our negotiations branch, to join me.

I'll start the question. First of all, let me start off by saying physicians recognize their obligations to their contractual obligations, and physicians recognize their responsibility to bill appropriately. There's no question of that. Our surveys of patients suggest that most Ontarians register within the kind of model you're describing of a family health organization and a family health group, and get service after hours and on weekends. As the Auditor General's described, at least half do, and we recognize what we're told by the college of family practice and by the Ontario Medical Association: that physicians aren't always as diligent in providing information through shadow billing mechanisms. It allows us to know that they were there.

We think the numbers reported by the Auditor General represent a minimum of performance, and that performance is better than that, but we're unable to say exactly what that is. I'll just comment on that generally.

The other thing that you've described is a belief that the first obligation that the ministry has in planning the evolution of the health care system is to listen to what Ontarians want and to recognize that patient choice is a crucial aspect of the way that our health system is organized.

Having said that, we can do a much better job of letting Ontarians know about their obligations to the system as well, to use the system appropriately. We're of the belief that physicians want information about their own practice. We're increasingly providing them with that kind of information. David Clarke's group, responsible for negotiations with the Ontario Medical Association, along with Mr. Graham, who you met

earlier, have done a lot of work looking at various sources of information to provide us with the ability to describe back to physicians what their service is like for their patients.

Is that fair, David? Do you want to describe some of the work that we've been doing with the health analytics branch to understand that better?

Mr. David Clarke: Absolutely.

Dr. Bob Bell: Thank you.

Mr. David Clarke: Thank you for the question. We have been looking at what kind of reports we can give physicians that will really help them understand what's going on in their practice and how they can better serve their patients. We have been looking at when people go to the emergency department, or, for outside use, better reporting back to the physician on just who went, so that the physician can follow up with them: "Why did you go there instead of coming to see me? Did you know that we were open?"

What we've heard from physicians and from the OMA is that sometimes patients go to the emergency department or to a walk-in because they didn't even know that the physician's office was open. So it's trying to get better information around that. That is something we have the information for. We are trying to design the reports that we can push out to the physicians on a regular basis that will give them that kind of information.

As well, a lot of it is just better education of the patients around what the hours of operation for the medical practice are. Sometimes you don't know that your family health team is open and that there's somebody there, or you believe that because your physician isn't there, you need to go somewhere else.

It's just better education for the patient around what their obligations are in terms of going to see their own physician or the physician group, and the benefits of seeing someone who has your medical information, and not just going to a walk-in or to the emergency department.

We're looking at how we better educate the patients, how we better educate the physicians around what is happening in their practice, and what kinds of reports that we can generate to do that.

As with just about anything to do with physicians, we have to work with the OMA. Some of these reports, and how we deal with the physicians under their contracts, are negotiated contracts with the OMA. We are trying to work through some of those details as well, in terms of what we can provide that would be most useful to the physicians.

Mr. John Fraser: That's great, because when I listen to some of the questions around the table and some questions that we had before, it's really evident that it's all about stewardship, right? It's a model of a collective. It's stewardship by both the practitioners and the ministry and us here, on behalf of the people of Ontario. If you just look at family health, it's complex, but yet the whole picture together is a pretty complex set of relationships.

My next question, though, is around physician supply in Ontario. How many physicians do we have in Ontario right now?

Dr. Bob Bell: Go ahead, David.

Mr. David Clarke: As the deputy said earlier—and it's actually in the auditor's report—there are about 30,000 physicians in the province, split between 14,000 or so general practitioners and 16,000 specialists.

It's a number that goes up pretty steadily. We've been seeing between 700 and 900 net new physicians per year entering practice in the province over the past number of years. We forecast, from what we can see with medical school enrolments and what we know of physicians' intent to retire, that we should see that number continue for a few years to come.

Mr. John Fraser: I'm just asking this around patient access. If you look at the distribution, first of all, inside competencies, do we have the right mix? Are we heavy somewhere and short somewhere else?

Secondly, regional: When we look at the challenges of patient access and people going to ERs, is there a geographical challenge that we have?

Mr. David Clarke: I think the geographic distribution is something that we've struggled with over the years. A lot of times, medical school students want to continue to practise where they were educated, where they've had some experience or where they grew up. It's a little tough sometimes to get them to go to other areas of the province where there is a high need. The Northern Ontario School of Medicine made a big difference in that for the north. People who come from the north and train in the north tend to stay in the north, so that has helped significantly there.

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But I think the big thing for us is dealing with the distribution issue. We have, over the past few years, looked at what we call "managed entry" for primary care into the FHO and FHN models. We were trying to concentrate to get people to go to those areas of the province that are high-need. We did get some people to go, but we didn't see the kind of numbers that we would really like to see. We're constantly looking for new strategies to get that distribution issue worked out.

Mr. John Fraser: When we look at not the geographical mix, but that specialist-versus-general-practitioner mix—your family physician—how are we in terms of that balance? What are some of the measures that were taken, as government, around general practice and family medicine to ensure that right kind of mix of practice?

Mr. David Clarke: I think we've made huge strides on the primary care side with the primary care reforms and the introduction of the models over the past 10 to 15 years. If you go back to 15 years ago, we had some significant problems with the supply of family doctors in the province. Now, we're doing quite well, and it is becoming a speciality of choice for physicians coming through medical school—

Mr. John Fraser: Excuse me, was it not before?

Mr. David Clarke: It was not previously. It was a real issue to get physicians to go into that. It just wasn't paying enough. The way that the fee-for-service structure worked for them was problematic.

Dr. Bob Bell: Maybe I'll add in, David, if I may. On the specialist side, the committee will probably be surprised to know that we actually have an oversupply of some interventional specialists now. My training is in orthopaedic surgery, as you know, Mr. Fraser. We have underemployed orthopedic surgeons in the province today, as we have underemployed ear, nose and throat docs, gastroenterologists and some interventional cardiologists.

As you know, it takes 10 to 12 years to train an orthopaedic surgeon. Entry into our training programs is based on the current market assessment of what the needs of the population are. Sometimes, you do get into a situation where we've oversupplied for the number of people who currently have resources to practise.

We're thinking that through in two ways. First of all, how do we make our assessment more accurate? It's fascinating; our medical schools and our post-graduate medical training programs are world leaders in shortening the length of time that it takes to achieve a speciality degree by introducing what's called "competency-based training." I'm proud to tell you that this model is now being copied around the world.

But again, at Mount Sinai Hospital, in the program in orthopaedic surgery where I used to practise—what this is based on is saying, "Here are the characteristics, here are the skill sets that an orthopaedic surgeon needs to achieve." That may take two and a half years; it may take five years.

That shortening of time training for interventional specialities is really essential to us. We can't afford to have people invest 12 years of their life and come out of training and find that their skill sets aren't needed.

They are trained for orthopaedic practice in Ontario. We're making arrangements now to look at mentorship models and ways of incorporating their tremendous skills into useful practice in Ontario. But we've really learned how to work with the post-graduate training programs to change the way that we're providing training to these highly skilled specialists.

Mr. John Fraser: That's great. I have more questions, but my colleague wants to ask one.

Mr. Lou Rinaldi: Thanks. I'll make it very, very brief. Thanks again for being here. I do see the numbers increasing in the last 10 or so years, mostly in primary care physicians.

In rural Ontario—that's where I stem from—we still have an issue with family docs, as far as numbers, especially as we get some to retire. They've been there a long time with practices of 3,000 patients, versus today's physician, with less than half of that number.

Are we looking at incentives? I know they practise where they want to practise. They're independent business folks to a certain extent, and I get that. But how can we change the mindset that there is an outside of Toronto, there is an outside of Ottawa? Are we doing anything about that?

Dr. Bob Bell: There are, in some ways, market mechanisms that are starting to have an impact on this issue.

When we look at the way that family medicine docs in particular want to practise, they want to practise within these comprehensive models. It's what the Canadian college tells us, what the Ontario college tells us and what the Ontario Medical Association tells us: This is the way new docs want to practise. In order to get into that comprehensive model, they can't work in walk-in clinics. They have to be able to attract a roster of patients who will sign up with them for comprehensive care. Many urban areas of the province now are getting to the point where there simply aren't rosters available, whereas in Prince Edward county, there may be.

So we're starting to get to the situation now where people are starting to search out. The need for care is part of the solution for where they open their practice—which is, as you described, independent contractors making decisions based on the investments they need to make in their primary care practice.

It's starting to have an impact. I was in Smooth Rock Falls a couple of years ago. There's a big problem with providing primary care. They were actually paying locum doctors from Quebec to come to Smooth Rock Falls to practise. I'm delighted that recently, two graduates from the Northern Ontario School of Medicine have established a comprehensive care model in Smooth Rock Falls—which is part of that challenge of rural health care.

The other thing you mentioned, Mr. Rinaldi, is that Ontarians are extremely satisfied with nurse practitioner-led clinics. When we look at rural parts of the province—if we look at New Liskeard, for example, we have two models of care in New Liskeard. There's a nurse practitioner-led model and there's a family health organization model—

M^me^ France Gélinas: And a community health centre.

Dr. Bob Bell: And a community health centre, yes. Thank you.

The Chair (Mr. Ernie Hardeman): And they're working very well.

With that, we'll go to the questioners, and the official opposition.

Ms. Lisa MacLeod: Thank you again, Bob, for being here. I just want to go back to the Patients First strategy. I just got an email, and I want to read it to you. As you are aware, we have been dealing with a bit of a crisis in Ottawa with respect to opioids, and we're trying to ensure that we can provide necessary emergency care to Ottawa patients who are either overdosing or who are addicted. This just came in. This is about a young man who has been sober for a bit.

"He went to the Montfort, telling them he wanted to commit suicide and couldn't take it anymore. He stayed there for eight hours and they released him. He hasn't eaten for days, looks terrible. No one in the family can deal with him anymore as he is so out of control that we just don't have the skills to look after him for 24/7.

"We continually beg him to contact his counsellor and let her know that he wants to go to rehab, but he knows as well as we that there isn't anything immediate. He is supposedly on a wait-list for ROH"—which is the Royal Ottawa Mental Health Centre—"but we don't know for sure, as he won't let us speak with anyone, so we're relying on his info.

"He took a car last week, trying to escape from his own madness, and got stopped for speeding and not even having a licence. He has no sureties, so there is officially a warrant out for his arrest because he isn't following court conditions.

"The family is in shambles. There's nothing they can say or do. They're begging the police to get him. He is suicidal. They have done nothing. We have begged the hospital and the counsellor. Nothing."

I wanted to get that on the record with you here. That's what my office is dealing with each and every day since this epidemic started. I know it's a bit off-topic, but at the same time, there is somebody who is falling through the cracks in our health care system today—mental health care, the justice system, and basic primary care. I just wanted to put that on the record. I let them know that I was going to raise it with you.

I've written several letters to the ministry about this crisis. I know it's a bit off-topic, but I wanted to put it on there. If you could respond—

Dr. Bob Bell: May I respond, Chair? First of all, I'll say I think we all recognize there is nothing more tragic and nothing more heart-rending that having a family member who is considered competent—capable of consenting, capable of making their own decisions—who has severe mental health concerns.

1430

The opioid crisis in Ontario—as you know, Ontario has one of the highest daily morphine-equivalent utilizations in the western world. That's a long-standing problem that has quite an evolution, but one that the ministry is absolutely committed to addressing. Minister Hoskins came out with his opioid plan in the fall, and certainly progress has been made since then.

If I may, Chair, I'll go into some of those details.

First of all, on the matter of surveillance, Dr. David Williams, the Chief Medical Officer of Health, is Ontario's overdose surveillance officer. We've put in a number of different elements of surveillance: first of all, excellent relationships with the coroner's office to ensure that we're getting as rapid as possible confirmation of deaths from overdose and, very importantly, the drug involved in causing the overdose for citizens. This data is never as timely as we want it to be. It always needs to go through the proving process that coroners need to take, but certainly, we're getting that data regularly now.

We're also getting data from the national ambulatory reporting system provided by CIHI, the Canadian Institute for Health Information, about near misses that occur in emergency departments. So we're getting that data, and Dr. Williams has established the approach here akin to a public health emergency. In a public health emergency, it's essential that information is being provided that allows for surveillance. Crucially, that allows us to identify—if there's a sudden uptick in near-miss overdoses in a region, that we're able to identify and talk to community safety officers about the fact that we're seeing a change in the pattern of near-miss overdoses in this area. Is there something that has changed in the supply chain of illicit drugs that accounts for this increase in opioid emergencies?

So that's one thing: surveillance and collaboration with law enforcement and looking for hot spots developing.

The other thing is, of course, the availability of naloxone and making naloxone available through pharmacies across the province, providing education to families and friends of folks with opioid addiction issues—how to use opioids, and pharmacists teaching people how to do that.

The other is the expansion of suboxone availability. Ontario has a large methadone program for addicted Ontarians who are maintaining their functionality through the use of methadone. We think that suboxone is chronically a better solution; there's good evidence for that. Also, suboxone can be provided in a comprehensive harm-reduction primary care model, where attention is paid not just to treating the daily opioid addiction, but also looking at the comprehensive approach to primary care and harm reduction that suboxone represents.

The other is investments in mental health and addiction services: an announcement about two months ago about community-structured psychotherapy, a focus on adolescent youth hubs, a focus on supportive housing for homeless folks who often fall into this category of opioid addiction, recognizing that you can't treat addiction without stable housing. Those investments are essential, and those ramp up into year 2.

The other thing we're looking at is the advice of the minister's expert table on mental health. They've given us good advice about how we need to look at resources available for detoxification, as well as harm reduction. These are all elements that fit into this comprehensive strategy.

We agree with you that the kind of heartache experienced by this family, your constituent, is something that needs to be a major area of focus for the Ministry of Health. We can't do enough to focus on this.

Ms. Lisa MacLeod: If I may, just a final one—sorry, Chair—is if I could, through you, request that you and the minister perhaps come to Ottawa and meet with some of these families to see what's happening. I've met with some of these children who are addicted. One started drugs at the age of 10.

I'm sorry this was off topic but it is very much at the forefront of my mind.

The Chair (Mr. Ernie Hardeman): Thank you very much. We will get back to the topic.

Mr. Yurek.

Mr. Jeff Yurek: Thanks, Lisa. I thought I'd give you the opportunity for this and let the government have a little quick commercial while they're at committee.

We can get back to the report. A question that came up earlier, discussing—maybe you can talk about it: How does the government track when a patient unrosters? We noted that there are quite a few people who don't go to a doctor and who are enrolled. They said that for males between 20 and 29, it's quite a few. I know my nephew can't find work in Ontario. He's working in BC and has been gone for a year. I'm pretty sure he never unrostered because he wouldn't even think twice to even consider it. How is that accomplished and who oversees that?

Dr. Bob Bell: You're absolutely right. The Auditor General has pointed out that there are rostered patients who are not receiving visits. You're quite right; people who leave the province may not be recognized.

The usual way that people are unrostered is if they choose to go to a different practitioner, then there is a process that—that practitioner is responsible for initiating an unrostering process and a re-rostering process. But we recognize that people who are not receiving care of any type are people who may have left the province.

On the other hand, I think it's really crucial to remember, and one mild disagreement I'd have with the Auditor General's report relates to—I was present in 2008 when the massive amount of work was undertaken to understand what should go into capitation of payments and what should go into the bundle of comprehensive care. It was recognized at that time that rostered young men, for example, don't go for that many services. So the gender-based and age-based and chronic-disease-based rostered process recognizes people like your nephew as someone who may not require many services. The payment received for a healthy young male is probably in the neighbourhood of, I'm going to guess, just over 100 bucks a year.

Mr. Phil Graham: It's under $100.

Dr. Bob Bell: It's under 100 bucks a year.

You're absolutely right. We need a better process for checking on people, trying to determine if they're still in the market, but it also needs to be recognized that that lack of engagement of services was part of what we looked at in 2008 when we built the comprehensive care model.

In some ways it would be unfair to the physician if we were to say, "You've got rostered patients who aren't receiving care. Well, that was part of the way that we figured out how much we would pay you for the patients who are receiving care."

Mr. Jeff Yurek: My next question—I think Randy had mentioned it earlier, but basically it's oversight, checks and balances in the system—

Interjection.

Dr. Bob Bell: I apologize. I've just been told rostered patients who leave the province are removed when they contact BC health for coverage there. So there is inter-provincial communication about patients applying for a health number elsewhere.

Mr. Jeff Yurek: If they bother to contact a health care provider in BC.

Dr. Bob Bell: Or if they apply for health insurance in BC. So provinces do collaborate.

Thanks, Pauline.

Mr. Jeff Yurek: So, basically, with oversight of the contract, the checks and balances in the system seem to be very few and far between. You look on the review of programs, the Diabetes Management Incentive, code 2002. You never reviewed the cost-effectiveness for 10 years after it was implemented and found minimal improvements that would have resulted in $8 million in savings a year. The $6-million ophthalmologist billing is something the government likes to tout every year, from 2012 up to, recently, 2016; however, there's no inspection function. You haven't really had an inspector function since 2005.

I would think that, as the contractor of services, it would be good practice to have oversight to ensure things are being met and fulfilled at the end of the day. It happens in other spaces of the government. Why is there no oversight or function for ensuring we're getting best value for dollars?

Dr. Bob Bell: First of all, I go back to the comment that I made earlier, that it is the professional responsibility of every physician to ensure that they are billing for services that (a) they have provided and (b), are appropriate bills for the services that were provided.

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Certainly, if physicians are not billing appropriately, they are referred to the College of Physicians and Surgeons as evidence of professional misconduct. We see stories about that from time to time.

The issue related to review of practice of exceptionally high billers: You refer to the top 12 billers currently in the province. These practices have been reviewed.

Let me just check and see what I can say about that.

Interjections.

Dr. Bob Bell: First of all, in all cases, we have undertaken an educational process, Mr. Yurek, and some of those physicians have been referred to the Physician Payment Review Board.

Mr. Jeff Yurek: How much time do I have?

The Chair (Mr. Ernie Hardeman): You have about four minutes.

Mr. Jeff Yurek: Perfect. The number of patients, as has been mentioned earlier, enrolled in a practice has increased, yet the wait time to see a doctor has worsened. It has gone in the wrong direction. Can you explain what's going on there? Again, I go back to oversight of a contract. If there are certain provisions in place in a contract to ensure access to care, how are we addressing that situation?

Dr. Bob Bell: Thank you. I just want to check. I don't believe that the access to primary care has worsened.

Mr. Jeff Yurek: The wait to see a doctor. It has gone from 51% to 57% who had to wait two days or more to see their doctor.

Dr. Bob Bell: Okay. That's within the family health organization model. I would say that probably it has

roughly remained about stable, if we look across all the models.

The thing that has changed is that we're measuring—that's based on our primary care surveys, which are undertaken for patients who are rostered, where we know where their doctor is. The thing to remember is that over the 10 years that these models have been introduced, the number of attached patients has increased from 75% to 94%, roughly.

Is that correct? How many were attached 10 years ago?

Interjection.

Dr. Bob Bell: Substantially fewer, anyway. We're measuring the experience of attached patients. What we're not telling you about, when we talk about those percentages of people able to get access within two days, is that previously, about 20% of Ontarians wouldn't have been measured because they didn't have attachment to any model of primary care.

Mr. Jeff Yurek: That leads me to my next question. Some 48% of doctors report they have an arrangement for the practice for patients to see a doctor or nurse when the practice is closed, without having to go to the emergency department. If you compare it to 10 other developed countries—which I prefer to compare our health care system to, in order to reach a standard of care—75% of doctors have that developed.

I'm seeing that you've enrolled a lot of patients, but the actual access to services, I believe, has decreased, which brings me back to oversight of the contracts. How are you enforcing to ensure they are meeting their terms and conditions?

Dr. Bob Bell: I think you're referring to the Commonwealth Fund data related to access to primary care that looks at access to primary care within 24 to 48 hours. It looks at emergency department utilization and looks at access to primary care services after hours.

You're absolutely right that we're not strong performers in primary care, compared to the national health system. That's something that we want to work on with the Ontario Medical Association.

Part of the reason for the introduction of the Patients First Act was to focus on performance improvement in primary care, and the primary performance measure that we're interested in improving is access to primary care within 24 to 48 hours.

The Ontario college agrees with us that this needs to improve. We're giving doctors, as you heard earlier from Mr. Clarke and Mr. Graham, more information about their practice. Some physicians don't actually realize that their patients are going elsewhere. We want to let them know about that.

Currently, our emphasis is on education, better data, working collaboratively with physicians, recognizing that we're into about year 8 of a comprehensive model that demonstrates improvement in a variety of different measures of quality of primary care.

The one measure that hasn't demonstrated as much improvement as we want is access within same-day, next-day constraints.

The Chair (Mr. Ernie Hardeman): And with that, we appreciate your contribution today, but it does take all the time we have. So thank you very much for being here today—

Dr. Bob Bell: Thank you, Chair. Thank you to the members. We appreciate it.

The Chair (Mr. Ernie Hardeman): —and helping us out.

The committee continued in closed session at 1445.

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